BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against:

Karen Christine Juncker
3555 West Alpine Avenue
Stockton, CA 95204

Registered Nurse License No. 271302

Respondent.

Case No. 2009 - 29

OAH No. 2008110249

DECISION

The attached proposed decision of the Administrative Law Judge is hereby adopted by the Board of Registered Nursing as its Decision in the above-entitled matter.

This Decision shall become effective on **May 27, 2009**.

IT IS SO ORDERED this **27th** day of **May, 2009**.

Susanne J. Phillips, MSN, RN, FNP-BC
Board of Registered Nursing
Department of Consumer Affairs
State of California

BEFORE THE
BOARD OF REGISTERED NURSING
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In the Matter of the Accusation Against:	Case No. 2009-29
KAREN CHRISTINE JUNCKER Stockton, CA 95204	OAH No. 2008110249
Registered Nurse License No. 271302, Respondent.	

PROPOSED DECISION

This matter was heard before Karen J. Brandt, Administrative Law Judge, Office of Administrative Hearings, State of California, on February 17 through 20, and 23, 2009, in Sacramento, California.

Brian S. Turner, Deputy Attorney General, represented Ruth Ann Terry, M.P.H., R.N. (complainant), Executive Officer, Board of Registered Nursing (Board), Department of Consumer Affairs (Department).

Karen C. Juncker (respondent) was present and was represented by Donna W. Low, Attorney at Law.

Evidence was received, the record was closed, and the matter was submitted on February 23, 2009.

AMENDMENTS TO THE ACCUSATION

At hearing, complainant amended the Accusation to delete all allegations relating to Patient B, as follows:

1. Complainant deleted paragraph 10.

2. On page 3, line 26, "treatment for Patients A and B" was amended to read "treatment for Patient A."

3. On page 4, line 6, "as set forth in paragraphs 9 through 11 ..." was amended to read "as set forth in paragraphs 9 and 11 ..."

FACTUAL FINDINGS

1. On August 31, 1976, the Board issued Registered Nurse License Number 271302 to respondent. Respondent's license was in full force and effect at all times relevant to the charges set forth in the Accusation, and will expire on November 30, 2009, unless renewed or revoked. The Accusation seeks to revoke respondent's license based upon allegations that, on January 28, 2003, respondent failed to timely triage, assess and arrange for treatment for Patient A.

2. Patient A was born on March 13, 1943. In March 2002, he had coronary artery bypass grafting (CABG) at St. Joseph's Medical Center (St. Joseph's) in Stockton. Patient A also had a pacemaker/defibrillator and diabetes. For two or three days before January 28, 2003, Patient A exhibited symptoms of the flu. During this period, Josephine Hume, Patient A's partner for 12 years, told Patient A that he should see his doctor. When Patient A refused, Ms. Hume threatened to call an ambulance and have him taken to the hospital. At about 9:00 p.m. on January 28, 2003, Patient A came to Ms. Hume and told her he wanted to go to the hospital. Ms. Hume drove Patient A to St. Joseph's. They did not call St. Joseph's ahead of time to tell the Emergency Department that they were coming. Patient A did not complain to Ms. Hume of chest pain.

3. Instead of parking outside St. Joseph's in the area designated for Emergency Department patients, Ms. Hume parked in the lot under the hospital. Ms. Hume and Patient A began walking from their vehicle to the Emergency Department. Partway to the Emergency Department, Patient A told Ms. Hume that he was having trouble breathing and could not make it. Using a telephone on the wall, Ms. Hume called the Emergency Department and asked for a wheelchair.

4. At approximately 9:20 p.m., Judy Lee, the Emergency Department secretary, received Ms. Hume's telephone call. Ms. Hume told Ms. Lee that Patient A was "short of breath" and asked whether someone was available to locate and guide them to the Emergency Department. Ms. Lee put Ms. Hume on hold and placed a call to Tammy Meeker-Rosso, R.N., the first-line supervisor in the Emergency Department. Ms. Rosso told Ms. Lee that the Emergency Department was in a "crisis situation" and that no Emergency Department nursing staff were available to assist Ms. Hume and Patient A. Ms. Rosso instructed Ms. Lee to notify Fraeya Buhr, R.N., the House Supervisor, of the situation. Ms. Lee called Ms. Buhr and was instructed to ask the Emergency Department security guard to locate Ms. Hume and Patient A, and transport Patient A by wheelchair to the Emergency Department.

5. The Emergency Department security guard located Ms. Hume and Patient A and transported Patient A by wheelchair to the Emergency Department through the back entrance.

6. Respondent was the only triage nurse working in the Emergency Department when Ms. Hume and Patient A arrived. She was in the triage room with a patient when the security guard came through the back entrance with Patient A at approximately 9:40 p.m. The security guard asked respondent where Patient A should go. Respondent stopped triaging the patient she was with and went into the hall. Respondent asked Patient A the nature of his problem and Patient A answered that he could not breathe. Respondent then asked him why he had come to St. Joseph's and Patient A replied that he had had his bypass surgery there in March 2002. Respondent stated that he "should be over that by now."

7. St. Joseph's has issued triage policies and procedures for its Emergency Department. The policies and procedures in effect in January 2003 stated that the "purpose of triage is to determine patient prioritization" by assessing "if the patient has an emergency medical condition and, if the emergency medical condition exists, to categorize the patient into the appropriate triage category." The policies and procedures established three triage categories:

Category I.	Emergent: Patients presenting with acute illness or injury where life or limb threatening emergency or could result in a permanent disability or death without immediate intervention.
Category II	Urgent: Patients presenting with a serious acute illness or injury where life or limb is not an immediate threat to well being, but that has the potential to develop such a threat if treatment is delayed.
Category III.	Routine: Patients requiring an emergency intervention for underlying illness/injury that may result in significant complications if treatment is delayed or left untreated.

The policies and procedures also provided that a patient would be considered to be in the "emergent" category if the patient had active chest pain or dyspnea,[1] or was in respiratory distress.

[1] The Merriam-Webster MedlinePlus Online Medical Dictionary defines "dyspnea" to mean "difficult or labored respiration." (http://www2.merriam-webster.com/cgi-bin/mwmednlm?book=Medical&va=dyspnea.)

8. While respondent was talking to Patient A, she was assessing him using the "ABCD" method of assessment: airway, breathing, circulation, and distress. Patient A was not visibly struggling to breathe. He spoke in full sentences and provided responsive information. He was not sweating. He did not complain of chest pain. While he looked pale, he did not otherwise appear to be in distress. From the quick ABCD assessment, respondent decided that Patient A did not belong in the "emergent" category. At hearing, respondent testified that, in her mind, she mentally placed Patient A in the "urgent" category and decided that she would triage him as her next patient. She asked the security guard to escort Ms. Hume and Patient A to registration, and told them that she would be with them as soon as possible.

9. St. Joseph's maintains an Emergency Sign-In Log for patients who walk into the Emergency Department seeking emergency care. The sign-in log includes spaces for the patient's name, reason for visit, date of birth, sign-in time, triage time, and comments. In the space for "reason for visit," the registration clerk puts a two- or three-word description provided by the patient. The registration clerk also enters the sign-in time. If a walk-in patient appears to be in extremis, the registration clerk will immediately call the triage nurse. Otherwise, the registration clerk will advise the triage nurse after a patient has registered. The triage nurse makes a determination of the order in which patients will be seen based upon when they register and the nature of their complaints. Patients are seen by the triage nurse in the order they register, unless the reason for their visit indicates that they may have a condition that requires immediate attention. In the "triage time" box, the triage nurse generally fills in the time when the patient is called for triaging.

10. The sign-in log for January 28, 2003, indicates that Patient A registered at the registration desk at 2142 (9:42 p.m.), and that the reason he gave for his visit to the Emergency Department was "can't breath." There is no time written for Patient A in the "triage time" box. Instead, the words "to back" are written in that box.

Factual Disputes

11. What occurred after Patient A registered is in dispute. The primary area of dispute is whether and to what extent respondent made an effort to triage Patient A between about 9:42 p.m., when he registered, and about 10:20 p.m., when she found him in the bathroom, a period of 38 minutes.

12. Ms. Hume testified as follows: When she and Patient A got to the registration window, she filled out papers given to her by a young man who appeared to be of Asian descent. While at the registration desk, Patient A tried to take his insurance card out of his wallet, but could not do so. Ms. Hume and Patient A began waiting in the waiting room. Ms. Hume asked Patient A if he was okay, and he told her that he could not breath. According to Ms. Hume, she went to the young man at the registration window and told him that Patient A could not breathe. The young man asked her if Patient A had seen the triage nurse and Ms. Hume responded "yes." Ms. Hume then sat down for what she estimated was

about 10 minutes. During this period, Patient A's head was hanging down on his chest and he had to "work at breathing." Ms. Hume returned a second time to the registration window and told the young man that Patient A could not breathe. According to Ms. Hume, the young man did not respond. After about ten minutes, Ms. Hume returned to the registration window a third time. This time a tall woman was at the window. The woman looked at the sign-in log and told Ms. Hume that Patient A would be "coming in pretty soon."

Ms. Hume testified that, when she returned to where she had been sitting in the waiting room, she was "amazed" to find that Patient A was not there. A person in the waiting room told her that Patient A had gone to the bathroom. Patient A had wheeled himself in his wheelchair to the bathroom without first telling Ms. Hume. Ms. Hume waited about five to ten minutes. When it seemed to her that Patient A had been in the bathroom for too long, she went to the bathroom door. Ms. Hume called for Patient A. When Patient A did not answer, Ms. Hume told the security guard that Patient A had been in the bathroom for too long.

While Ms. Hume was waiting outside the bathroom, respondent came out of the triage area and said to Ms. Hume, "I've been looking for you." Ms. Hume responded that Patient A was in the bathroom and would not "answer her." Respondent asked the security guard if he had keys to the bathroom door and the security guard said he did not think so. According to Ms. Hume, respondent asked to try the security guard's keys and got the bathroom door open. Patient A was slumped over the toilet. Respondent flushed the toilet, yelled for help, and started CPR. Patient A was pronounced dead shortly thereafter.

According to Ms. Hume, while she was in the waiting room with Patient A, she did not hear anyone call Patient A's name.

13. Shortly after Patient A died, Ms. Hume made a tape recording of her recollection of the events on January 28, 2003. The transcript of that recording is different from Ms. Hume's testimony in some important respects. First, the transcript states that Ms. Hume went to the young man at the registration desk only once, and not twice, and that, after she told him that they had seen the triage nurse, the young man stated, "well, it will be a little bit." The description of how Ms. Hume learned that Patient A had gone to the bathroom is also different in the transcript from Ms. Hume's testimony. The transcript states that, after Ms. Hume talked to a "stocky woman" at the registration desk, she:

> went back and sat down and told [Patient A], "it will be pretty soon [Patient A], pretty soon." So, he in turn, wheeled his chair over to the men's room and went into the men's room and I thought he had just gone down the hall till I seen the chair was empty, and that he had gone into the men's room. So I waited, checked my watch. I waited a few minutes, and I went over to the men's room and I said to the guard that was sitting at the desk. I said, "you know, he's been in there too long, he's been in there way too long...."

This passage indicates that Ms. Hume was aware when Patient A wheeled himself away from the waiting room and apparently made no offer to assist him. It also suggests that Patient A may have been in the bathroom longer than Ms. Hume estimated during her testimony, before she became concerned and alerted the security guard.

There was no indication in either the transcript or Ms. Hume's testimony that the young man at the registration desk contacted respondent after Ms. Hume told him of Patient A's condition or that Ms. Hume asked to speak to the triage nurse directly.

14. Respondent's testimony was different from Ms. Hume's testimony in several important respects.

At hearing, respondent could not remember which patient listed on the sign-in log she was triaging when the security guard wheeled Patient A through the back entrance of the Emergency Department. As set forth above, the sign-in log indicates that Patient A registered at 2142 (9:42 p.m.). The log also shows that a patient born on February 10, 1960, and complaining of "chest pain" registered at 2123 (9:23 p.m.) and was called by respondent for triage at 2128 (9:28 p.m.). In addition, the log shows that a child born on January 30, 2002, with a complaint of "abd pain vomiting" registered at 1958 (7:58 p.m.) and was called by respondent for triage at 2136 (9:36 p.m.). At hearing, respondent did not know whether she was triaging the patient complaining of chest pain or the child when Patient A first arrived. She testified that, unless a patient complaining of shortness of breath is in extremis, she would consider a patient complaining of chest pain to have a more urgent condition and would triage that patient first.

According to respondent, after quickly assessing Patient A in the hallway, she continued triaging the patient in the triage room. Respondent could not remember the exact chronology of the events that occurred after she finished triaging that patient. She testified that, at some point during the period in question, a private doctor came into the triage office and complained about his patient, who had been waiting in the waiting room for over five hours after she had been triaged. That night, because the Emergency Department was in a crisis situation, there were no empty beds. Respondent had therefore returned several patients to the waiting room after triaging them, until beds and an Emergency Department doctor became available. Respondent called her supervisor about the complaining private doctor. An LVN was assigned to assist the private doctor and his patient.

Respondent also testified that between the time when she first saw Patient A in the hallway and when she found him in the bathroom, she made two sweeps of the waiting room to look for him. According to respondent, before the first sweep, she looked at the sign-in log to determine who was still waiting to be triaged and their complaints. She then looked for Patient A and Ms. Hume in the very crowded waiting room, but did not see them. Respondent could not remember if she called out Patient A's name during her first sweep through the waiting room. She testified, however, that she made a circle around the waiting room, and when she did not see Patient A, she called the next patient on the sign-in log. According to the log, the next patient who was triaged was born on February 9, 1934, had a

complaint of "↑ temp," and had registered at 2015 (8:15 p.m.). Respondent noted on the log that she called him for triage at 2156 (9:56 p.m.). Before taking that patient into the triage room, respondent asked Teresa Morodomi, the registration clerk, to "keep an eye out for" Patient A.

Respondent testified that during her second sweep of the waiting room, she called out Patient A's name, but neither he nor Ms. Hume responded. Respondent told Jill Marello, the registration clerk who came on duty after Ms. Morodomi, that she was looking for a "Caucasian man in a wheelchair" and asked Ms. Marello to continue to "keep an eye out for him." Shortly thereafter, Ms. Marello told respondent that there was a patient in a wheelchair in the waiting room complaining of difficulty breathing. When Ms. Marello brought that patient to respondent in the triage room, respondent told Ms. Marello that the patient was not the one she was looking for. After doing a quick assessment of that patient, respondent sent him back to the waiting room and asked for Patient A to be brought in. The sign-in log reflects that a patient born on January 13, 1940, registered at 2216 (10:16 p.m.) complaining of "diff breathing." In the box for "triage time," 2219 (10:19 p.m.) is crossed out, and replaced by 2236 (10:36 p.m.). Respondent stated that this was the patient in the wheelchair that Ms. Marello brought to her, and that he was initially brought to her at 10:19 p.m., the time crossed out.

After Ms. Marello brought that patient back to the waiting room, respondent went into the waiting room and saw Ms. Hume standing by the bathroom door. Patient A's wheelchair was also outside that door. Respondent said, "I've been looking for you" to Ms. Hume. Ms. Hume responded that Patient A had been in the bathroom a long time and was not answering. According to respondent, she asked the security guard for a master key. When he did not have one, she asked Ms. Marello for a paperclip. Ms. Marello brought respondent a paperclip and respondent opened the bathroom door with it. When she opened the door, she saw Patient A on the toilet, slumped over, motionless, cyanotic, and not breathing. Respondent put Patient A on the floor. She noticed that Patient A had made a bowel movement. Respondent flushed the toilet, asked Ms. Marello to call a code blue, and began giving unprotected mouth-to-mouth resuscitation and chest compressions to Patient A. St. Joseph's emergency team responded to the code blue, including a respiratory therapist and Ms. Rosso. Their attempts to revive Patient A were not successful. He was pronounced dead at 2305 (11:05 p.m.).

15. Ms. Marello also testified at hearing. Her testimony confirmed much of respondent's testimony. According to Ms. Marello, in January 2003, she worked the 10:00 p.m. to 6:30 a.m. shift as the registration clerk. It was her custom to arrive at the Emergency Department at 9:50 p.m. On January 28, 2009, she arrived at work no later than 9:50 p.m. When she arrived, Ms. Morodomi[2] asked her if she had seen a large, Caucasian gentleman in a wheelchair. Ms. Morodomi told Ms. Marello that respondent had called for this gentleman in order to triage him, but he could not be located in the waiting room, reception area, or triage area. Ms. Morodomi also said that this gentleman had "disappeared" after being

[2] Ms. Morodomi died in April 2006 after a car accident.

escorted into the reception area by the security guard and that, before 9:50 p.m., respondent had both called for him and walked through the registration area looking for him. Ms. Marello testified that she walked out the front door to look for Patient A. When she did not see him, she returned to the registration area and, at about 9:58 p.m. called his name on the loud speaker. No one responded.

Ms. Marello also testified that at about 10:05 or 10:06 p.m., respondent came to Ms. Marello at the registration desk and said that she was looking for Patient A and, if Ms. Marello saw him, she should not "let him out of [her] sight." Ms. Marello looked in the waiting room, but did not see Patient A. According to Ms. Marello, respondent came into the registration area twice looking for Patient A. Ms. Marello also confirmed that she brought a patient in a wheelchair who was having difficulty breathing to see respondent, but respondent stated that that patient was not the one she was looking for and sent him back.

In addition, Ms. Marello testified that, to her knowledge, no young man of Asian descent worked at the reception desk on the night of the incident. She and Ms. Morodomi were the only two people who worked the reception desk that night. At no time that evening did Ms. Hume come to her to tell her that Patient A was having trouble breathing.

16. On January 28, 2003, after Patient A died, respondent completed an Occurrence Report. In her report, respondent wrote:

> @ 2219 I went to WR [waiting room] to get [Patient A] to triage him. I didn't see him in WR so I knocked on ♂ BR [men's bathroom] door, no answer, door locked. Security in WR opened door. [Patient A] was sitting on toilet [with] head down between his legs, apneic [and] blue in the face. I pulled him to the floor, positioned him [and] began CPR. My telephone went offline after being dropped during episode. I had reg. clerk [and] security to call a code blue. I gave mouth to mouth without a barrier. [Patient A] was lifted to gurney on board [and] taken to Rm #9, CPR [and] bagging in process.

17. On January 28, 2003, Ms. Rosso assisted with the code blue on Patient A. She also completed an Occurrence Report that night. In her report, Ms. Rosso wrote:

> Judy Lee, DS, received [a] phone call @ appprox. 2120 from female voice stating she was with a male pt in the Basement wandering the hallways by the classrooms looking for the ER (after parking in the parking garage) [and] complaining that he couldn't breath. Judy asked me (T. Rosso) what to tell this woman. I told her to please call the House Supervisor, because we had too many ICU 1 on 1 pts in ED [and] were @ crisis. House Supervisor asked Judy to call security to locate [and] retrieve pt. Butch (security guard) brought pt to ED

> Registration Window to sign in @ 2142, via w/c [wheel chair]. It was stated by Patient Family that patient care was delayed so long by Nursing staff, and yet family did not bring patient to well lit, appropriately designated by street sign, ED entrance.
>
> Also to be noted after registering patient, the patient locked himself in the bathroom with wife standing outside for unknown amount of time and triage nurse unable to locate patient for approximately [illegible] – 8 minutes, before wife spoke up and stated where he was. If triage nurse [respondent] has not been diligent in her search for this patient, the triage wait would have been much longer due to the nature and complaints of waiting patients on triage list and number still to be triaged. This triage nurse, [respondent] is to be highly commended for efforts and the initiation of unprotected ventilations at beginning of CPR process due to necessity of speed of treatment [and] no assistance [at] that point.

At hearing, Ms. Rosso testified that, on January 28, 2003, she talked to respondent and the registration staff, including Ms. Marello, to obtain the information she included in her Occurrence Report. According to Ms. Rosso, the registration staff told her that respondent had made "multiple trips" to the waiting area that night to look for Patient A. During her testimony, Ms. Rosso emphasized just how overcrowded and busy the Emergency Department was that evening. The Emergency Department has 28 beds. That evening, 34 patients had been admitted, with six patients either on gurneys in hallways or held in the ambulance bay. There were a number of patients waiting in the waiting room after being triaged. There were three patients who had registered before Patient A who had not been triaged by the time he registered. Ms. Rosso had called Ms. Buhr seeking help for the Emergency Department's crisis situation, but no help was provided.

18. The Department of Health Services (DHS) investigated St. Joseph's handling of the incident. During the course of the investigation, DHS did not interview Ms. Morodomi, Ms. Marello or Ms. Rosso. On July 24, 2003, DHS interviewed Vinh To, a St. Joseph's registration clerk. Mr. To told DHS that he occasionally worked in the facility, but had no recollection of the events on January 28, 2003.

On July 24, 2003, DHS also interviewed respondent over the telephone about the incident. Respondent was pulled off her triage duties to respond to the interview. She was not told about the interview before she received the telephone call. She did not have any medical records or reports in front of her when she responded to DHS's questions.

The information that respondent gave to DHS over the telephone, as reflected in the DHS investigation report, is different from the testimony she gave at trial in several important respects. Respondent told the DHS investigator that, after she dealt with the private physician, she finished triaging other patients, "when the secretary approached her

and told her there was a patient in the waiting area complaining of difficulties breathing. She told the secretary to bring the patient to the triage area. The secretary brought other patient to the triage room, and not [Patient A]. At that time, [respondent] went to the waiting area to look for [Patient A] (she knew how [sic] he looked like but not his name). [Patient A's] 'wife' told her the patient wheeled him self [sic] to the bathroom a while ago and she worried he may not be well. [Respondent] asked the guard to open the door and found the patient on the toilet unresponsive and not breathing."

There is no information in the DHS investigation report to indicate either that respondent looked for Patient A in the waiting room or that she knew and called his name before Ms. Hume told her that he was in the bathroom.

19. Gary Johnson, a senior investigator for the Department's Division of Investigation, also conducted an investigation for the Board in this case. He did not interview Ms. Morodomi, Ms. Marello, or Ms. Rosso. He did not review Ms. Rosso's Occurrence Report. On January 10, 2005, he interviewed respondent. Respondent also sent a letter dated January 11, 2005, to Mr. Johnson describing the incident. There is no indication in either Mr. Johnson's investigation report or in respondent's letter that she looked for Patient A in the waiting room, or that she knew and called his name before Ms. Hume told her that he was in the bathroom.

20. There was also no indication on the sign-in log that respondent called for Patient A before she found him in the bathroom. As set forth in Finding 9, the sign-in log includes a "triage time" box and, in that box, the triage nurse generally fills in the time that a patient is called for triaging. In the "triage time" box for Patient A, there is no time; instead, there are only the words "to back." According to Ms. Rosso, it is St. Joseph's policy that, when a triage nurse calls for a patient and the patient does not answer, the triage nurse is to wait 15 minutes and then call for the patient again. If the patient does not respond a second time, the policy provides that the triage nurse should note in the "triage time" box the second time the patient was called and include an "NA" for "no answer." The sign-in log for January 28, 2003, includes NA's next to the triage times for some other patients. There is no NA next to Patient A's name.

21. These inconsistencies in the evidence with respect to whether and when respondent made an effort to triage Patient A after she saw him in the hall raise some concerns. But even with these inconsistencies, given Ms. Rosso's Occurrence Report written the night of the incident, Ms. Hume's testimony that respondent stated that she had been looking for Patient A, and Ms. Marello's testimony that both she and respondent looked for Patient A on January 28, 2003, respondent's testimony that she made an effort to find Patient A before Ms. Hume told her he was in the bathroom was credible.

22. The inconsistencies in Ms. Hume's testimony are more troubling. Although Ms. Hume testified that she was concerned about Patient A's condition, she testified that she was not aware that he had wheeled himself to the bathroom until she was informed by someone in the waiting room. If Ms. Hume failed to notice that Patient A had wheeled

himself to the bathroom, it is conceivable that she also failed to hear respondent or registration staff call his name or notice them looking for him. The evidence was also not clear about how long Patient A may have been in the bathroom before Ms. Hume alerted St. Joseph's staff. From the transcript of Ms. Hume's recollections dictated shortly after January 28, 2003, it may have been longer than her hearing testimony suggested. What is clear is that Patient A did not tell either Ms. Hume or St. Joseph's staff that he was going to the bathroom, and that, before he died, he was able to wheel himself to the bathroom, get off his wheelchair, enter the bathroom, lock the door, pull down his pants, and make a bowel movement without any assistance.[3]

Expert Opinions

23. Complainant retained Marion Korin, R.N., Assistant Nurse Manager, Emergency Department, University of California Davis Medical Center, as an expert in this matter. Ms. Korin received an Associate Degree in Nursing from Somerset Community College in New Jersey in 1984. She was first licensed as an R.N. in 1984 in New Jersey. She has been certified as an Emergency Nurse since 1990. She has been licensed by the Board as an R.N. since 2004. She also has a paralegal degree and acts as a medical/legal consultant. She first worked as a Charge Nurse in an Emergency Department in 1993. During her career, she has often worked as a triage nurse.

24. On September 27, 2007, Ms. Korin reviewed records in this case and issued a written expert report. In her report, Ms. Korin stated that:

> The Standard of Care as defined by the Emergency Nurses' Association is as follows: The scope of Emergency Nursing Practice involves the assessment, analysis, nursing diagnosis, outcome identification, planning, implementation, of interventions and evaluation of human response to perceived, actual or potential, sudden or urgent, physical or psychological problems that are primarily episodic or acute which occur in a variety of settings.

Ms. Korin also cited to St. Joseph's triage policies and procedures, which she described as requiring that "all patients presenting to the emergency department are to be assessed and triaged in a timely manner in order to determine the urgency of their complaint. This assessment is to include vital signs." In addition, Ms. Korin referred to California Code of Regulations, title 22, section 70125, in defining the role and responsibilities of a registered nurse as providing "initial and ongoing assessments and formulat[ing] a plan of care."[4]

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[3] It was also troubling that Mr. Johnson did not interview Ms. Morodomi, Ms. Marello or Ms. Rosso, or review Ms. Rosso's Occurrence Report during the course of his investigation. Although Ms. Morodomi was the registration clerk on duty when Patient A registered and may have been able to provide significant information, it appears that neither DHS nor Mr. Johnson made any attempt to interview her before she died in April 2006.

[4] California Code of Regulations, title 22, section 70215 provides:

In her report, Ms. Korin opined that respondent did not triage Patient A, because she did not take his vital signs or properly assess him. Ms. Korin opined further that respondent's encounter with Patient A in the hallway before he registered did not constitute an assessment according to the standard of care set forth above or the mandates of California Code of Regulations, title 22, section 70125.

According to Ms. Korin's report, respondent was negligent in the care of Patient A because she departed from the standard of care quoted above and California Code of Regulations, title 22, section 70215, by failing to assess and triage him when he presented to the Emergency Department. Ms. Korin also opined that respondent was "incompetent in her general triage decisions" because she failed to triage and assess Patient A in a timely manner. According to Ms. Korin, Patient A's complaint of difficulty breathing is "generally considered [an] emergent triage categor[y] requiring immediate intervention." Although Ms. Korin did not imply that there was a causal link between respondent's failure to timely assess Patient A and his death, Ms. Korin did find that respondent did not follow the standard of care and demonstrated "a lack of knowledge and critical thinking in her triage decisions."

25. At hearing, Ms. Korin opined that respondent's conduct was incompetent and negligent, but not grossly negligent. She stated that she deemed respondent's January 11, 2005 letter to Mr. Johnson to be the most important information she reviewed. According to Ms. Korin, when respondent saw Patient A briefly in the hallway, she learned that he had had

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Planning and Implementing Patient Care.

(a) A registered nurse shall directly provide:

(1) Ongoing patient assessments as defined in the Business and Professions Code, Section 2725(d). Such assessments shall be performed, and the findings documented in the patient's medical record, for each shift, and upon receipt of the patient when he/she is transferred to another patient care area.

(2) The planning, supervision, implementation, and evaluation of the nursing care provided to each patient. The implementation of nursing care may be delegated by the registered nurse responsible for the patient to other licensed nursing staff, or may be assigned to unlicensed staff, subject to any limitations of their licensure, certification, level of validated competency, and/or regulation.

(3) The assessment, planning, implementation, and evaluation of patient education, including ongoing discharge teaching of each patient. Any assignment of specific patient education tasks to patient care personnel shall be made by the registered nurse responsible for the patient.

(b) The planning and delivery of patient care shall reflect all elements of the nursing process: assessment, nursing diagnosis, planning, intervention, evaluation and, as circumstances require, patient advocacy, and shall be initiated by a registered nurse at the time of admission.

(c) The nursing plan for the patient's care shall be discussed with and developed as a result of coordination with the patient, the patient's family, or other representatives, when appropriate, and staff of other disciplines involved in the care of the patient.

(d) Information related to the patient's initial assessment and reassessments, nursing diagnosis, plan, intervention, evaluation, and patient advocacy shall be permanently recorded in the patient's medical record.

bypass surgery, he could not walk, and he could not breath. Ms. Korin opined that, given these three facts, at a minimum, respondent should have taken Patient A's vital signs. According to Ms. Korin, if respondent had taken Patient A's vital signs, she would have obtained more information upon which to base a determination about whether Patient A was an emergent or urgent patient. Ms. Korin opined that respondent was incompetent because she failed to conduct a more thorough evaluation when she first saw Patient A in the hallway. According to Ms. Korin, this failure indicated a lack of skill ordinarily possessed by a competent nurse. Even if respondent decided to finish triaging the patient she was with before taking Patient A's vital signs, Ms. Korin opined that respondent should have triaged Patient A when she was finished with that prior patient. According to Ms. Korin, there was no indication in the records that she received to indicate that respondent went into the waiting room to look for Patient A after he had registered.

Ms. Korin disputed that respondent's ABCD assessment constituted either a triage or an adequate substitute for a triage. While Ms. Korin recognized that the fact that St. Joseph's Emergency Department was extremely impacted that night added extra challenges, she disputed that this crisis situation justified respondent's failure to conduct an adequate assessment of Patient A. Ms. Korin also found it inconsistent for respondent to have rejected a patient in a wheelchair who was brought to her in "moderate respiratory distress" in order to triage Patient A first, but did not think Patient A was in sufficient respiratory distress to triage him immediately. Ms. Korin stated that, because Patient A was a diabetic, he could have been having cardiac problems without any chest pain symptoms. According to Ms. Korin, when respondent first saw Patient A in the hallway, she should have told him to stay there, she was going to finish with the patient she was seeing, and she would take him next. Ms. Korin opined that, given the facts that Patient A had shortness of breath, was 10 months post-bypass surgery, and was not feeling well for several days, respondent should have treated him as a more emergent patient from her first contact with him, and not allowed him to wait in the waiting room. Ms. Korin opined further that, once respondent had met Patient A in the hallway, she had a duty to conduct a more thorough assessment of him before sending him to the waiting room, and that, in the absence of such an assessment, she did not have sufficient information to determine that Patient A was an urgent, rather than emergent, patient. Although Ms. Korin recognized that respondent could not triage two patients at the same time, Ms. Korin opined that, when respondent was interrupted by Patient A's arrival, she should have quickly determined whether he could safely wait for a few minutes, finished with the patient she was with, and then immediately triaged Patient A. According to Ms. Korin, respondent's failure to act in this manner constituted incompetence and negligence.

26. Respondent called two expert witnesses: Michael MacQuarrie, M.D., F.A.C.E.P., F.A.E.E.M., and Katherine Kelly, R.N., M.S., F.N.P., C.E.N.

27. Dr. MacQuarrie is a 1966 graduate of Dartmouth College and a 1970 graduate of Cornell University Medical College. He is board-certified in internal medicine and emergency medicine. Since 1978, he has been the Chair of the Emergency Department of Tahoe Forest Hospital. He is on the hospital's Quality Assurance Committee and Critical

Care Committee. He has been involved in developing the hospital's audit procedures for the Emergency Department, and has approved the hospital's nursing policies.

28. After reviewing the records, reports and declarations, Dr. MacQuarrie issued a written expert report. In his report, Dr. MacQuarrie opined that respondent was not negligent in her assessment of Patient A. According to Dr. MacQuarrie's report, when Patient A was wheeled into St. Joseph's Emergency Department, respondent's evaluation of his complaint, appearance and speech indicated that he did not have a critical emergent condition. Respondent, therefore, did not interrupt her triage of the patient she was then with. Respondent did, however, plan to triage Patient A next. According to Dr. MacQuarrie, respondent's decision was appropriate given her obligation to the other patient and the stable appearance of Patient A. But Dr. MacQuarrie opined that, given Patient A's medical history and complaint of difficulty breathing, it was appropriate to make him the next patient to be seen and triaged. In Dr. MacQuarrie's opinion, it was "above and beyond" the standard of care for respondent to have interrupted her evaluation of one patient to make "even a cursory evaluation of a patient wheeled in by a wheelchair." According to Dr. MacQuarrie's report, respondent made a "diligent effort to seek" Patient A, to ensure that he would be the next person triaged. In addition, Dr. MacQuarrie believed that respondent's efforts in getting the bathroom door open and trying to resuscitate Patient A showed that respondent is a professional and caring nurse. Dr. MacQuarrie also opined that, even if Patient A had been treated as an emergent patient and given immediate attention, it would not have prevented his death that night, in light of his low ejection fraction, severe ischemic cardiomyopathy and life-threatening arrhythmia.

29. At hearing, Dr. MacQuarrie opined that respondent made the appropriate clinical decision when, after she quickly assessed Patient A, she chose to return to triaging the patient she was with. According to Dr. MacQuarrie, that quick assessment was adequate to establish that Patient A: (1) had an airway and could breath, as evidenced by his ability to speak in full sentences; (2) had good circulation, as evidenced by the fact that he was not fainting; and (3) was not in severe distress, as evidenced by the way he was acting. In addition, Patient A was not sweating or breathing rapidly. Dr. MacQuarrie opined that, given this information, respondent's decision to continue triaging the patient she was with and to take Patient A as her next triage patient was appropriate.

Dr. MacQuarrie also reviewed Patient A's medical records, including the blood work done after his death and his death certificate. Patient A's death certificate states that the immediate cause of his death was asystole,[5] and that he had had an acute myocardial infarction months before his death and coronary artery disease years before his death. According to Dr. MacQuarrie, based upon the information in these records, particularly Patient A's troponin level, Patient A did not have a myocardial infarction immediately before

[5] The Merriam-Webster MedlinePlus Online Medical Dictionary defined "asystole as "a condition of weakening or cessation of systole." (http://www2.merriam-webster.com/cgi-bin/mwmednlm?book=Medical&va=asystole.) It defines "systole" as "the contraction of the heart by which the blood is forced onward and the circulation kept up." (http://www2.merriam-webster.com/cgi-bin/mwmednlm?book=Medical&va=systole.)

his death. Instead, Dr. MacQuarrie opined that, given Patient A's 12 percent ejection fraction and significant history of severe ischemic cadiomyopathy and arrhythmia, he died from sudden cardiac arrest brought on by his straining to make a bowel movement.

30. Ms. Kelly is an Assistant Professor of Nursing at California State University, Sacramento. She teaches courses in Advanced Medical Surgical/Critical Care. She is also a Nurse Practitioner at Rideout Hospital in Marysville and a Family Nurse Practitioner in Yuba City. She earned a Bachelor of Science degree in Nursing in 1979 from California State University, Los Angeles, and a Master of Science degree and Family Nurse Practitioner Certificate in 2002 from the Orvis School of Nursing Graduate School, University of Nevada, Reno. Since 1979, she has been licensed as an R.N. by the Board. Since 2003, she has been licensed as a Nurse Practitioner. She was certified as an Emergency Nurse in 1990.

31. After reviewing the records, reports and declarations, Ms. Kelly issued a written expert report. In her report, Ms. Kelly explained that the role of a triage nurse in an emergency department is "difficult and complex," and is generally reserved for the most experienced emergency nurses. The role requires the triage nurse "to sort the large number of patients presenting to the emergency department to determine the most critical (chest pain, respiratory distress, hemorrhage) patients from the urgent (febrile illness, shortness of breath, altered mental status) and non emergent patients (sprained ankle, cold, sore throat)." Ms. Kelly also noted that, because many patients have no health care and use emergency departments for their primary care, emergency departments became "extremely impacted" on a daily basis.

In this case, Ms. Kelly found that respondent determined from her initial encounter with Patient A that he: (1) was speaking in complete sentences and therefore was breathing adequately; (2) was alert and could answer questions appropriately; and (3) was pink and not diaphoretic (sweating) and therefore was not in extremis. Ms. Kelly opined that, given these facts, it was appropriate for respondent to direct Patient A to the registration desk to register, while she continued to triage the patient she was with.

According to Ms. Kelly's report, the ABCD assessment method utilized by respondent is a primary assessment tool used by many healthcare providers, including triage nurses, paramedics, physicians, and disaster team workers, to make a quick determination of the acuity of a patient in order to prioritize when presented with multiple patients seeking emergency care. Because St. Joseph's Emergency Department was extremely impacted that night, respondent's ABCD assessment was an efficient and effective tool for evaluating the acuity of Patient A's condition.

In her report, Ms. Kelly disputed Ms. Korin's assessment that respondent should have considered Patient A to be an emergent patient because he complained of difficulty breathing. St. Joseph's policies and procedures state that "respiratory distress" qualifies as an emergent condition. According to Ms. Kelly, there is a difference between a patient in respiratory distress and one who claims that he has shortness of breath and is not feeling well. As Ms. Kelly's report explained, a patient in respiratory distress cannot speak in

complete sentences, is anxious, may be disoriented, and is unable to answer even simple questions. This was not the presentation of Patient A. He was alert, pink and dry, and answering questions appropriately and in full sentences.

In sum, in her report, Ms. Kelly opined that, on a very busy evening in St. Joseph's Emergency Department, respondent "did her best to sort and assess the patients that presented to her. She made astute and appropriate decisions with the information she had. She utilized resources to the best of her ability and followed the guidelines of the facility. Additionally, she demonstrated appropriate prioritization, substantial knowledge base and advanced critical thinking skills."

32. At hearing, Ms. Kelly disputed Ms. Korin's opinion that respondent did not triage Patient A. According to Ms. Kelly, respondent's ABCD assessment was a form of triage, which allowed respondent to effectively sort patients and prioritize them for full triage. Ms. Kelly opined that, in her short conversation with Patient A, respondent was able to ascertain Patient A's level of consciousness (whether he was awake, alert and able to answer questions), his respiratory pattern (whether he was having difficulty breathing and talking, or could speak in full sentences), and his skin color (whether he was sweaty and distressed or calm and dry). According to Ms. Kelly, this quick assessment process was a valid tool for respondent to utilize to determine that Patient A was not in extremis and did not require immediate attention. Given the results of this quick assessment, respondent prudently and properly decided to continue triaging the patient she was with, to send Patient A to the registration desk, and to conduct a full triage on Patient A as soon as she was able. As Ms. Kelly explained, when multiple patients seeking emergency care present in an Emergency Department at the same time, a triage nurse must make tough decisions about prioritizing these patients.

According to Ms. Kelly, for a nurse to be deemed to be incompetent, it must be shown that she does not have the knowledge, skill or ability to perform her duties as a nurse. From all that Ms. Kelly could discern from the records she reviewed, respondent wrote good notes, she had the training and background to do her job, she was favorably reviewed by her supervisors, and she was considered by other nurses in the hospital to be a resource. Ms. Kelly opined that respondent was not incompetent, but, instead, was a skilled, knowledgeable and capable triage nurse.

Ms. Kelly opined that neither St. Joseph's policies and procedures nor the applicable standard of care required respondent to place Patient A in the emergent category based solely upon the facts that he had arrived in the Emergency Department by wheelchair, complained that he could not breath, and had had heart bypass surgery 10 months earlier. According to Ms. Kelly, there was no indication that Patient A was in respiratory distress or had acute and active chest pain. Ms. Kelly explained that, if Patient A was having a cardiac problem when he first presented to respondent, there would have been some indication that his blood was not flowing to his important organs: he would have been unable to answer questions completely and coherently, he would have been sweating, and he would have been breathing with evident difficulty. Patient A did not present with any of these symptoms. There were

no indications that Patient A was in extremis when respondent quickly assessed him. In sum, Ms. Kelly opined that respondent complied with the standard of care applicable to triage nurses, and made decisions that were reasonable and accurate under the circumstances.

33. As set forth in Legal Conclusion 3 below, whether respondent may have been negligent in triaging Patient A is not a relevant inquiry in this matter. Given the allegations in the Accusation, the only relevant inquiry is whether respondent's actions on January 28, 2003, establish that she was incompetent. California Code of Regulations, title 16, section 1443 defines "incompetence" to mean "the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5." California Code of Regulations, title 16, section 1443.5 provides:

> Standards of Competent Performance.
>
> A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:
>
> (1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.
>
> (2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.
>
> (3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.
>
> (4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.
>
> (5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.
>
> (6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client,

and by giving the client the opportunity to make informed decisions about health care before it is provided.

34. When all the evidence is weighed and balanced, the opinions of Dr. MacQuarrie and Ms. Kelly were most persuasive. As Dr. MacQuarrie and Ms. Kelly opined, respondent's initial assessment of Patient A in the hallway was sufficient to determine that he was not in an emergent condition that required her to leave the patient she was then triaging to attend to him.

35. The more difficult question is whether respondent should have known from her brief hallway assessment that Patient A's condition was so urgent that she needed to keep him by her side and fully triage him as her next patient, as Ms. Korin stated. As Dr. MacQuarrie and Ms. Kelly persuasively opined, Patient A did not present with symptoms that indicated that he was having a heart attack. He was not struggling to breath; he was able to speak in full, coherent sentences; he responded appropriately to questions; and he was not sweating. Although Ms. Hume asserted that Patient A had to "work at breathing," he had sufficient breath and strength to wheel himself to the bathroom, get out of his wheelchair, lock the door, pull down his pants, and use the toilet without any assistance. These facts support respondent's decision, made after her quick assessment, that Patient A was not in an emergent condition and could be referred to registration before he was fully triaged.

36. Since 1989, respondent has been a Staff Nurse III in the Emergency Department at St. Joseph's. She received an Associate Degree in Nursing from the College of Marin in Kentfield, California. In 2004, she graduated from California State University, Hayward, with a Legal Nurse Consulting Certificate. She is a Certified Emergency Nurse, Mobile Intensive Care Nurse, Advanced Cardiac Life Support Provider, and Pediatric Advanced Life Support Provider. In 2000, she prepared a Triage Teaching Module to help train nurses working in St. Joseph's Emergency Department. This module shows that she has significant knowledge about the duties and responsibilities of a triage nurse.

Felisa Sison, R.N., respondent's first-line supervisor, described respondent as a "mentor with excellent skills." According to Ms. Sison, during the seven years she has worked with respondent, she has found respondent to be highly competent clinically, compassionate, knowledgeable, methodical and intelligent, and a diligent worker who goes out of her way to assist patients and their families. Ms. Sison often assigns respondent to train students and new staff. According to Ms. Sison, respondent's experience and excellent clinical skills are highly regarded by St. Joseph's nurses, who often go to her for clinical advice and guidance.

Cheryl Ann Heaney, R.N., has been the Director of St. Joseph's Emergency Department since January 2005. She has had many opportunities to assess respondent's knowledge, skills and abilities. Ms Heaney rated respondent's skills as "at the very top" when compared to other nurses. Ms. Heaney described respondent as a very skilled, experienced, knowledgeable, conscientious and dedicated emergency room nurse.

37. On January 28, 2003, respondent was the only triage nurse working in a very hectic and overcrowded emergency department. From the evidence presented in this case, respondent exercised reasonable clinical judgment to assess and prioritize the patients who presented to her that night. Given Patient A's non-emergent condition when respondent first met him in the hallway and his ability to wheel himself to the bathroom, complainant did not prove by clear and convincing evidence that respondent, in her assessment of Patient A, lacked or failed to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse. Consequently, complainant failed to establish that respondent was incompetent.

LEGAL CONCLUSIONS

1. Because complainant is seeking to revoke respondent's professional license, complainant bears the burden of proving cause for disciplinary action by clear and convincing evidence to a reasonable certainty. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 855-856.)

2. Pursuant to Business and Professions Code section 2761, the Board may suspend or revoke a registered nurse's license if the nurse has engaged in:

> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

3. In the Accusation, complainant has alleged that respondent's failure to triage Patient A in a timely manner constituted incompetence and unprofessional conduct. At hearing, complainant's expert witness opined that respondent's conduct was incompetent and negligent, but not grossly negligent. Because Business and Professions Code section 2761, subdivision (a)(1), specifically defines "unprofessional conduct" to include "gross negligence," a registered nurse's license cannot be disciplined for negligent conduct that does not rise to the level of gross negligence. Consequently, the only allegation of unprofessional conduct in the Accusation that constitutes cause for disciplinary action is incompetence.

4. As set forth in Finding 33, California Code of Regulations, title 16, section 1443 defines "incompetence" to mean "the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5." In *Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1054-1055, the court explained the criteria for determining whether conduct constitutes incompetence as follows:

> The term "incompetency" generally indicates "an absence of qualification, ability or fitness to perform a prescribed duty or function." (*Pollack v. Kinder* (1978) 85 Cal.App.3d 833, 837.) Incompetency is distinguishable from negligence, in that one "may be competent or capable of performing a given duty but negligent in performing that duty." (*Id.*, at p. 838.) Thus, "'a single act of negligence ... may be attributable to remissness in discharging known duties, rather than ... incompetency respecting the proper performance.'" (*Ibid.*, quoting from *Peters v. Southern Pacific Co.* (1911) 160 Cal. 48, 62 [116 P. 400].) The *Pollack* court concludes: "While it is conceivable that a single act of misconduct under certain circumstances may be sufficient to reveal a *general* lack of ability to perform the licensed duties, thereby supporting a finding of incompetency under the statute, we reject the notion that a single, honest failing in performing those duties--without more--constitutes the functional equivalent of incompetency justifying statutory sanctions." (85 Cal.App.3d at p. 839, italics in original.)

Given the definition of incompetence set forth in California Code of Regulations, title 16, section 1443 and *Kearl*, it cannot be found that respondent's actions in this matter constituted incompetence. As set forth in Finding 37, complainant did not prove by clear and convincing evidence that respondent lacked or failed to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse. Consequently, complainant failed to establish that respondent was incompetent in her assessment of and conduct regarding Patient A. The Accusation should, therefore, be dismissed.

ORDER

The Accusation against Karen C. Juncker is DISMISSED.

DATED: March 20, 2009

KAREN J. BRANDT
Administrative Law Judge
Office of Administrative Hearings

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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **KAREN CHRISTINE JUNCKER** 3555 West Alpine Avenue Stockton, CA 95204 Registered Nurse License No. 271302	Case No. 2009-29 **ACCUSATION**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. ("Complainant") brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

2. On or about August 31, 1976, the Board issued Registered Nurse License Number 532554 to Karen Christine Juncker ("Respondent"). Respondent's registered nurse license was in full force and effect at all times relevant to the charges brought herein and will expire on November 30, 2009, unless renewed.

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STATUTORY PROVISIONS

3. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.

5. Code section 2761 states, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions. . .

6. Regulation 1443 states:

> As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.

COST RECOVERY

7. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

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FIRST CAUSE FOR DISCIPLINE

(Incompetence)

8. At all times herein mentioned, Respondent was employed as a triage nurse in the emergency department of St. Joseph's Hospital ("SJH") in Stockton, California. Respondent was on duty from approximately 2140 hours through approximately 2328 hours on January 28, 2003.

9. On or about January 28, 2003, at approximately 2140 hours, Patient A, 59 years of age, arrived at the emergency department at SJH. Patient A was unable to make it from the parking lot to the Emergency Department on his own due to severely decreased breath and required transportation in a wheel chair by a SJH security guard . The request for the assistance was made directly to the Emergency Department. Patient A's past medical history provided to the Respondent included weakness, difficulty breathing for the past three days and open heart surgery in March 2002. The Respondent stated the patient should be over the surgery and then assisted the patient to the Emergency Department waiting room without taking any vital signs contrary to SJH written protocols if effect at that time. The Emergency Department registration records classified patient A as "Emergent" after Respondent was aware of Patient A's complaints, medical history and conducting a visual examination.

10. On or about January 28, 2003, at approximately 2220 hours, Patient B, 56 years of age, arrived at the emergency department at SJH with the complaint of chest pain. The patient's past medical history was significant for hypertension.

11. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a)(1), on the grounds of unprofessional conduct. On or about January 28, 2003, while on duty as a triage nurse in the emergency department at SJH, Respondent was incompetent, within the meaning of Regulation 1443, because Respondent failed to exercise the appropriate degree of care in medical decisions by failing to timely triage, assess and arrange treatment for Patients A and B. These acts and omissions were also incompetent because they violated SJH written protocol.

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SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

12. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), in that on or about January 28, 2003, while on duty as a triage nurse in the emergency department at SJH, Respondent committed acts constituting unprofessional conduct, as set forth in paragraphs 9 trough 11 incorporated herein.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 271302, issued to Karen Christine Juncker;

2. Ordering Karen Christine Juncker to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and

3. Taking such other and further action as deemed necessary and proper.

DATED: 7/31/08

RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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